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**Rural Health Care Outreach Grant Narrative**

**NEEDS ASSESSMENT**

The Senior Outreach Services (SOS) Consortium, comprised of nine health care agencies in rural State, will provide outreach and community based mental health and substance abuse treatment services to older adults. First County Mental Health Center, the applicant agency, has piloted a small project in First County, State, that provides outreach, in-home therapy, and community based case management focusing on the elderly population. Through the Senior Outreach Services Consortium outreach and community based services will be expanded in First County and initiated in Second County, State.

The Senior Outreach Services Consortium will consist of the following service agencies:

- Area Agency on Aging (AAA)
- First County Public Health Department
- Second County Public Health Department
- The Sanctuary at County Regional Hospital (area provider of geriatric psychiatric care)
- Behavioral Health Unit at County Regional Medical Center
- Flower Valley Assisted Living
- Gran Villa Assisted Living Facility
- Gran Villa Assisted Living Facility
- Sunshine Assisted Living
- First County Mental Health Center

*Target Population:*

The target population is older adults, age 60 or older with unmet mental health and substance abuse treatment needs. These seniors are currently not being served by traditional methods due to financial, structural, and personal barriers including access and stigma. Program recipients will be older adults who are continuing to live in their own homes or are in assisted living facilities. The untreated mental health and substance abuse issues of these individuals put them at risk for exacerbation of physical health problems, suicide attempts, premature moves to long-term care settings, and psychiatric hospitalization or residential alcohol/drug treatment.

*Needs of the Target Population:*

Limited access to mental health services for Americans age 60 and older is identified by the Surgeon General's Report on Mental Health as an increasing risk for suicide, psychiatric hospitalization, and premature placement in long-term care facilities (Department of Health Human Services, 1999). Males, 85 and older, have the highest rates of suicide of any other group at 21 per 100,000 (Center for Disease Control, 1999). The majority of older adults, who commit suicide, have diagnosable depression (Conwell, 1996). The American Association for Geriatric Psychiatry testified that "there is accumulating evidence that depression can exacerbate the effects of cardiac disease, cancer, strokes, and diabetes (2005)."

The Department of Health and Human Services Surgeon General Report (1999) report estimates that at least 19.8% of older Americans (over age 55) experience mental illness. If one considers

the challenges faced with aging, it becomes clear that this is not a coincidence. Declining physical health, personal losses, reduced independence, and financial burdens are just of the few issues faced by many older adults. Many people see seniors as just "slowing down" when in fact they may be exhibiting symptoms of undiagnosed and untreated depression. Misconceptions by providers, family, and seniors themselves result in failure to refer seniors for diagnosis and treatment that in turn can lead to serious consequences for seniors which can include the following:

- Increased risk of suicide
- Increased risk for both psychiatric and medical hospitalization
- Premature placement in nursing homes
- Exacerbation of physical problems
- Alcohol and/or drug abuse or dependence

The emotional and financial costs of each consequence are apparent. Both the statistics and personal observations show that many older adults are in need of mental heath or substance abuse treatment. Unfortunately only a few actually receive services. Almost two-thirds of older adults with a mental disorder do not receive needed services (Rabins, 1996). However, if diagnosed and treated 60% to 80% of older adults will benefit from treatment (Schneider, 1996). In rural communities, the rate of older adults accessing services on their own is particularly low due to a variety of factors including stigma and access issues.

U.S. Census data (2000) indicates that there are 10,792 residents over age 60 in First and Second Counties. Based on the Administration on Aging estimate of 19.8% of older adults experiencing a mental illness, there are approximately 2,137 older adults in these two counties in need of mental health services.

Between July 1, 2004 and June 30, 2005, only 224 individuals age 60 and older were seen at First County Mental Health Center. That number increased to 280 for the July 1, 2005 to June 30, 2006 time period as a result of initiating outreach and community based services on a small pilot basis. With limited resources for this project, services still fell very short of the projected need. While a few older adults may have received services from other sources, other providers in the area are virtually non-existent. First County is the main provider of mental heath care for First and Second Counties with only two other providers listed as having offices in these counties.

As the population continues to age, the need for mental health treatment for older adults will continue to escalate. Citters and Bartel (2004) project that the number of older adults with mental illness will more than double from seven million in the year 2000 to 15 million by the year 2030. The mental health system is not currently equipped to prepare for this growth. First County Mental Health Center is aware of this growing need and developed Senior Outreach Services (SOS) as a small pilot program to provide outreach and community based services to begin addressing service needs for this population.

Mental health service needs are not the only area of treatment need for aging adults. Substance abuse among the elderly is a growing problem for the health care industry. According to the National Center on Addiction and Substance Abuse (CASA) at Columbia University, substance

abuse related care accounted for 23 percent or nearly one-fourth of the total Medicare payments for hospital care. As the Baby Boomer generation moves into their senior years, carrying along patterns of behavior developed in the 1960's and 1970's, this situation will potentially become worse. Reverting back to alcohol and other substance use may be more likely for this population when faced with the many challenges of aging.

The 2002/2003 Substance Abuse Mental Health Service Administration (SAMSHA) National Survey estimated that 34.4% of adults age 65 or older had consumed alcohol in the past month at the time of the survey; 7.2% reported binge drinking; and 1.8% acknowledged heavy alcohol use. The number of older adults in need of substance abuse treatment in 2000 was estimated at 1.7 million and expected to increase to 4.4 million by 2020. According to Bartels, Blow, Brockmann, and Citters (2005), studies in primary care settings found 10-15 percent of older patients met criteria for at-risk or problem drinking. Although alcohol problems are common in older adults, they tend to go unrecognized.

Prescription drug abuse is another significant problem area for the aging. Although nationally seniors make up about 12 percent of the population, they are prescribed 30 percent of all drugs. Older adults tend to be more sensitive to drugs. Over-medicating and combining of prescription drugs with alcohol can lead to falls and injuries, accidental overdose, dependency, and impaired ability to function independently. This in turn leads to increased medical and social costs. Combined difficulties with medication misuse and alcohol may affect up to 19 percent of seniors according to a 2005 report prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA).

As with mental health problems, the majority of older adults with substance abuse or dependence problems do not receive needed treatment. It is estimated that only 11.9 percent of the 1.7 million older adults with substance abuse treatment needs identified nationally in 2000/2001 received treatment. Substance abuse in older citizens tends to not be detected as this population is not as involved in mainstream society. There are fewer people around to notice. They are less likely to have contact with the police or to lose a job or career due to their alcohol use. The majority of older adults receiving substance abuse treatment are those who have begun drinking heavily in mid or late life, and this is even truer for women than men. State data from the Addiction and Prevention Services in 2006 shows alcohol abuse and dependence problems are more prevalent than abuse of any other substance.

Based on the SAMSHA report of 10-15 percent of older adults being in need of substance abuse treatment for alcohol problems, this would translate to between 1,079 and 1,618 older adults in need of treatment for alcohol abuse and dependence in First and Second counties. However, the reality is that only 25 persons age 60 and over were seen in our substance abuse treatment programs between July 1, 2005 and June 30, 2006 at First County Mental Health Center. This represents less than 1.5 to 2 percent of those in need receiving services. This is far from the national average of 11.9 percent of those in need receiving services. Clearly these older adults with substance abuse issues are not being reached through existing traditional community mental health and substance abuse treatment services.

*Involvement of the Target Population and the Community in Project Development:*

Over the past eleven months, First County Mental Health Center has presented various informational programs through the existing Senior Outreach Services project targeting both older adults and service agencies for seniors. Mental health screenings have also been provided at senior community sites. These community presentations have provided an opportunity to ask members of the target population, family members, and service providers for input about the need for mental health and substance abuse treatment services for older adults and how the need could best be met. In addition to verbal requests for input, questionnaires at recent presentations have included a question about what First County could do to improve access for this population. Presentations provided over the past year have included, but are not limited to, American Association of Retired Persons (AARP), Flower Valley Assisted Living, Penn Terrace (a facility that offers low income housing to seniors), the First County Rotary Club, Stephen's Ministry, and the First County Health Department. In addition, meetings have been held with staff of the Southeast State Area on Aging, Gran Villa Assisted Living, Mercy Hospital Auxiliary, and Senior Services (area providers of services to seniors including Meals on Wheels).

A group meeting was held with existing Senior Outreach Service clients of First County Mental Health Center where this group was asked their ideas regarding services needed for older adults. These were individuals age 60 and above who are involved in mental health services due to the outreach efforts of the existing SOS program. On questionnaires provided, group members rated the in-home services, group and individual therapy, and socialization group currently offered through Senior Outreach Services as extremely useful. Two participants commented on the importance of community socialization opportunities provided through Senior Outreach Services. Responses to client satisfaction surveys distributed to Senior Outreach Service recipients reflect the benefit clients perceive themselves as receiving from this project and client feedback supports the need for expansion of community based services for this population. Members of our current client population have repeatedly verbalized to existing staff that there is a need for this project to expand. On multiple occasions, clients have asked if one of the SOS staff could visit a friend or relative that they believe may be dealing with mental health or substance abuse disorders and in need of help. The value of in-home services has been repeatedly and consistently emphasized by clients, families, and community members.

Feedback and input have also been received from primary care physicians in First County and this has been very positive. Two primary care physicians in First County that have been heavily involved in the existing project are Dr. Johns and Dr. Smith.

Primary care physicians in Second County have asked to refer clients, but First County has been unable to respond to those referrals due to not having staff available for Second County. Funding of the Senior Outreach Services Consortium project would allow for two direct service providers in Second County. Second County physicians are eager to have that resource available to their geriatric patients. Dr. Brown is one of the primary care physicians in Second County who would like to see services expand to older adults he is serving. The Sanctuary, a geriatric psychiatric inpatient facility located in the Regional Hospital, in Second County would utilize community based services for follow-up of patients discharged from that facility if they were

available. There are also several assisted living facilities such as Gran Villas in Second County that have residents who could benefit.

Public health departments, that also provide home health care services to older adults, have been included in the project development. The First County Public Health Department and Second County Public Health Department have been involved in the development of the proposed project and have agreed to be members of the Senior Outreach Services Consortium. The Southeast State Area on Aging has worked closely with the existing SOS pilot project and was instrumental in development of the initial pilot. The Area Agency on Aging is a resource for many needed services for seniors, but does not have a way to provide mental health or substance abuse services directly. They rely on community mental health to meet this need. Not only has the Southeast State Area on Aging been a part of project development, they have also agreed to serve on the Consortium. A local chapter of the American Association of Retired Persons has provided a letter of support for this project.

*Involvement of Local, Regional, and State Government:*

At the state and local government levels, input and letters of support have been obtained from the Office of Local and Rural Health with the State Department of Health and Environment; State Governor's Office; the State Department of Mental Health; Addiction and Prevention Services (AAPS) for the State of State; the First County Commission; the Second County Commission; and the First County Mental Health Center Board of Directors. Input from these agencies was solicited through personal contacts, telephone calls, and provision of written information about the tentative project proposal with requests for input and feedback. The final product has received excellent support from key agencies and groups at both the state and local levels of government.

The First County Board of Directors, many of whom are in the target population age group, have supported the concept of community based mental health and substance abuse services from the inception of the Senior Outreach Services pilot and are extremely supportive of the Consortium proposal that will bring agencies in our community together on behalf of older adults.

*Barriers to Services:*

Since there is an obvious need for mental health and substance abuse treatment services demonstrated both by statistical data and the input from consumers and the community, what prevents older adults from accessing traditional mental health and substance abuse services? Potential barriers have been identified as follows:

- *Stigma towards receiving mental health and substance abuse services:* Stigma is the most consistent barrier encountered. In response to our community presentations, seniors, repeatedly say that they believe mental illness to be a weakness or "something you don't talk about." Others cite fear of being committed to the state hospitals and do not wish for people in community to see their vehicles parked at the mental health center. Negative news stories, inaccurate Hollywood depictions, and the "pull your self up by the bootstraps" ideology is a significant influence on senior's view towards the mental health

system. Older adults equate mental health with "crazy people" It is easy to understand why so many from the 70 to 80 age group are not comfortable seeking treatment. These beliefs are even more amplified in the rural settings of First and Second Counties.

Identifying one's self as having a substance abuse problem or a "drinking problem" is also not easy at any age. Older adults tend to have more of an image of some one with an alcohol problem as a down and out full-blown "alcoholic" who has exhausted all their resources and alienated friends and family. Older adults may lack information and education about substance abuse problems, especially prescription abuse. They also may be reluctant to be seen at a place for "alcoholics" and "drug addicts". The in-home component of the project allows for connections to be made without the older adult having to make a physical appearance at the community mental health or substance abuse treatment agency.

- *Education for other service providers is needed in the community*: Mental illness in seniors is not recognized by healthcare providers. Depression in older adults is often termed "slowing down" and assumed to be a normal part of aging, while numerous areas of research prove this to be false (Department of Health & Human Services, 1999). Both patients and service providers have limited understanding of mental illness and are not trained on how to recognize signs and symptoms in seniors. Substance abuse is often an overlooked problem in older adults by healthcare providers. Many primary care providers may assume this is not an issue and not ask the necessary questions to uncover a problem with alcohol or other drug abuse.

- *Economic:* Many older adults have medical bills, high medication costs, fixed budgets, and limited incomes. It is particularly difficult for seniors, who only have Medicare, to see mental health services as something they can afford. The 2005 White House Conference on Aging Post Event Summary references how the Medicare program "discriminates against those with mental illness by requiring beneficiaries to pay a 50% co-payment for outpatient mental health services as opposed to a 20% co-payment for everything else." In fact, many seniors are not aware that mental health services or alcohol drug treatment are covered by Medicare at all.

- *Geographic/Lack of Transportation*: Significant numbers of older adults no longer have access to transportation or have physical problems preventing them from leaving the home. Older adults, who still have transportation, are often uncomfortable driving long distances. This is especially true for the rural communities located on the outskirts of both First and Second County.

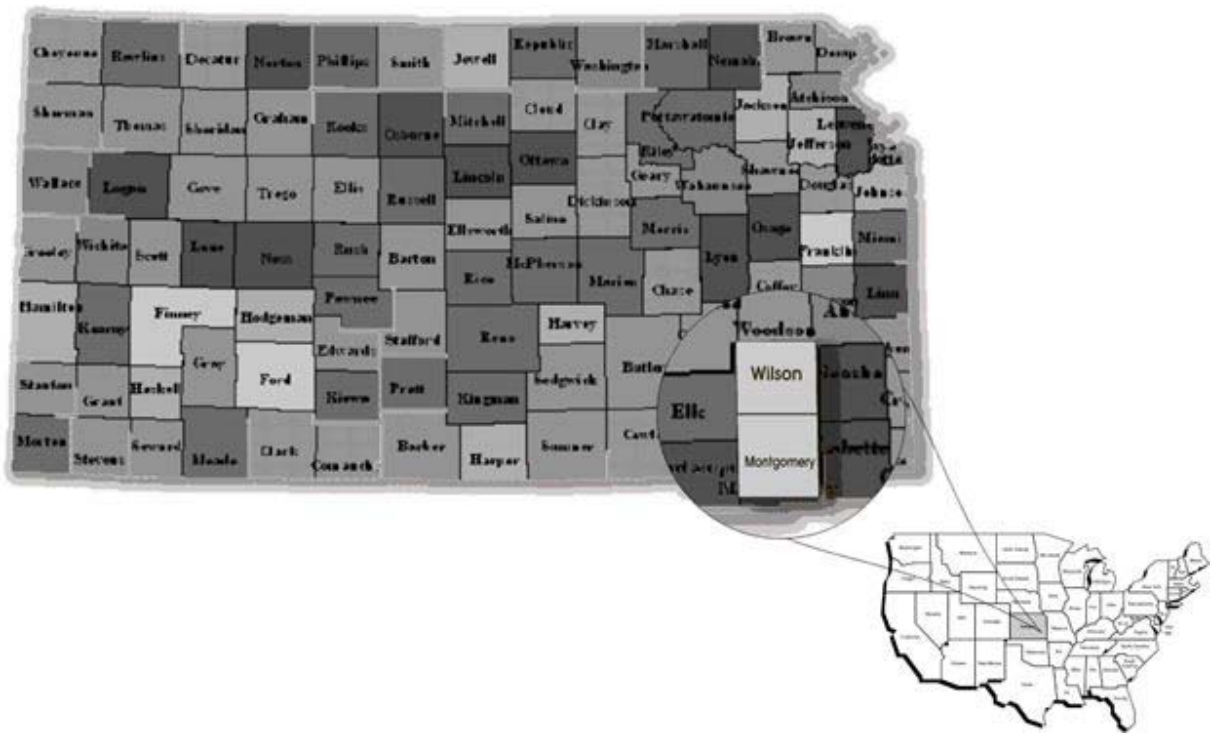
- *Lack of awareness of service availability & benefits of services: S*eniors do not consider First County as a resource and view it as a place for younger people. They do not understand the benefits of therapy or counseling or the process. Limited knowledge of service availability also impacts access. Seniors do not consider counseling as an option while they are struggling with mental illness and normally go to their primary care doctor with psychological issues. It is estimated that 50-70% of all primary care medical visits are related to psychological factors such as depression and anxiety (American

Psychological Association, 2004). Mental illness in older adults and substance abuse is often co-occurring with physical problems as well. In these situations, both primary care providers and the patient may fail to recognize First County as a resource often placing more emphasis on physical needs. However, research has shown that treatment of mental health disorders can result in better outcomes for those with chronic disease (American Association Geriatric Psychiatry, 2005).

*Geographical & Demographic Features:*

The Senior Outreach Services Consortium will be developed in Southeast State in First and Second Counties. State is located in the middle of the United States and has a heavy concentration of rural areas. Second and First both are designated as rural counties eligible for the Rural Health Care Outreach Grant Program. These counties are located in the Southeast area of State with the southern portion of First County bordering the State of Oklahoma.

The map below provides the location of the targeted counties plus delineates State in relationship to the United States.




The physical geography consists of flat farm land areas surrounded by tree covered rolling hills. This area of State still has working family owned farms that produce crops of wheat, corn, oats, sorghum, and soybeans. There is industry in both of these counties. Some of the larger employers in First County are Cessna Aircraft plant that produces small airplanes; Standard Motor Products that produces automobile parts; and Amazon.Com, an internet based marketing business. In Second County, Corp Industries is a large producer of luxury watercraft. There are two community colleges in First County, and two hospitals. Second County also has two community hospitals, one of which has a geriatric psychiatric unit.

First County Mental Health Center will be the lead agency for the Senior Outreach Services Consortium. The main office of First County Mental Health is located in Independence, State. Independence is the county seat for First County and is the second largest town in the county with 9,846 people (2000 Census). Independence is known as more of a business or "white collar" town. A second fully staffed office is located in Brownsville, State. Brownsville is the largest town in First County with 11,021 people (2000 Census). Brownsville is considered an industrial based or "blue collar" town. There are several smaller towns in First County. Carin and Valeton, State, have populations slightly above 2,000. The remaining communities in First County of Elmerton, Tinden, Oak, Liberty, Morgan, and Second City each have populations of less than 450 people.

In Second County the two highest population areas are in Kenburg and Frandon. Frandon is the county seat for Second County and has a population of 2,600 while Kenburg population is 2,848 people (2000 Census). First County has an office facility located in downtown Kenburg plus a satellite office at the Second County Hospital is used to see clients in Frandon.

In First County persons over age 65 comprise 17.8% of the population. Second County is even higher with 19.4% of the population above age 65. Both counties have a significantly higher percentage of elderly than the State of State which has 13% age 65 and above. The national percentage is even lower at 12.4%. (These percentages are based on 2004 estimates.) The population of these two counties is predominately white with 86.7% white residents in First County and 97.3% white in Second County according to 2004 data leaving a very small percentage of non-white residents in both these counties.

Not only do these two rural counties have a high percentage of elderly, the income level is quite low with a median average household income of $31,795 for the two counties as compared to a national median income figure of $43,318 based on 2003 data. In the primary population centers for these two counties (consisting of Kenburg, Frandon, Brownsville and Carin) the percentage of individuals age 65 and over who fell below the poverty level in 1999 ranged from a high of 17.5% in Kenburg to a low of 8.7% in Frandon.

*Health Care Service Availability:*

First County Mental Health Center is the main provider of mental health and substance abuse services in First and Second County State. Under the "Mental Health Information & Treatment Centers, Counselors" section of the most recent area AT&T Yellow Pages, only two other mental health providers with offices in First County are listed. There is not any outpatient mental health or substance abuse treatment providers located in Second County other than First County Mental Health Center. There is one Alcohol Drug Safety Action Program in First County listed in the yellow page with an office in Coffeyville that provides services for individuals charged with driving under the influence of alcohol or drugs, but there is not an addiction counseling service listed with offices in either of the target counties other than First County Mental Health Center.

The catchment area served by First County Mental Health Center, consisting of First, Second, Third and Fourth counties, is designated as a medically underserved area. First County is listed as a service site with the National Health Services Corps (NHSC) with a HPSA score of 17. Mental health clinicians with private practice status providing services at First County are eligible for the National Health Services Corps Loan Repayment Program.

Since other providers of mental health and substance abuse services are virtually non-existent, the addition of staff for this project will not adversely impact any other practitioners in this geographic area. The addition of mental health and substance abuse service providers will augment and enhance services to this in need population of older adults.

In regard to referral patterns, the Senior Outreach Services Consortium will add a needed resource for referrals from primary care physicians. The project will also augment and enhance services already in place through the Southeast State Area Agency on Aging. Essentially this addition to community resources will be a "win-win" for other agencies and providers who deliver services to older adults.

**RESPONSE**

In order to address mental health and substance abuse treatment needs for older adults (age 60 and above) residing in First and Second County, the Senior Outreach Services Consortium project will pursue the following goals:

- Develop and maintain a Consortium of community agencies involved in elder care to address mental health and substance abuse treatment needs and related issues for older adults
- Improve elder care by providing increased access to mental health and substance abuse treatment services
- Improve mental health status for program recipients as evidenced by decreased symptoms of mental illness and substance abuse resulting in improved quality of life and functioning
- Reduce stigma and increase community awareness of mental health and substance abuse issues for older adults in First and Second County communities through the SOS Consortium

Each of the proposed project goals will facilitate rural health care outreach services that will address the mental health and substance abuse treatment needs of seniors who are currently not receiving services in these two counties. The Consortium will enhance collaboration between community agencies and provide an advocacy group to develop and identify resources for this population. Eight agencies serving First and Second County have committed to joining First County Mental Health Center, the applicant agency, to form the initial group for the Senior Outreach Services Consortium. These consortium members will bring representation from public health, the Area Agency on Aging, community hospitals, and assisted living facilities. The common goal of this group will be to facilitate health care access for older adults to improve overall quality of life for this population; decrease risk of psychiatric and medical hospitalization; reduce suicide rates in this population; avoid premature placement in long-term

care facilities; and avoid exacerbation of medical problems related to untreated mental health and substance abuse problems.

Service availability will be increased by adding additional community based direct service providers consisting of one full time equivalent (1 FTE) clinical therapist and one full time equivalent (1 FTE) Case Manager to the two existing direct service staff that have been involved in the First County Senior Outreach Services pilot project in First County.

While in-office services are available to seniors in these communities, data demonstrates that seniors are not accessing office based services due to stigma and other barriers. Individual outreach and screening services will help address the stigma many seniors associate with coming to the mental health center. Outreach contacts may involve one session or multiple sessions depending on the individual's circumstances and needs. Outreach services will be provided at no cost to the individual or referral source. If the individual agrees to services, these will be provided on a sliding fee basis. A zero fee option for therapy or counseling services will be available for financial hardship situations, and Medicare, Medicaid, and insurance will be utilized when available to help provide financial sustainability for the project. In addition to individual and family in-home therapy, group therapy will be available to program recipients.

Experience in the pilot project has demonstrated that older adults who would never come to a mental health center are receptive to services via outreach. Many referrals quickly become comfortable with seeing a therapist after one or two outreach sessions, and do decide to proceed with treatment services. The in-home aspect also helps clients who are unable to transport themselves to mental health appointments due to physical, geographical or economical reasons.

Case Management services are not typical service activities provided by community mental health to this population. In several states, including State, Case Management has become an important service component for targeted populations, such as severely and persistently mentally ill adults (SPMI) and severely emotional disturbed children (SED) that is reimbursable through Medicaid. Unfortunately, this is not a service available to elderly with mental health issues that have had later life onset of mental health symptoms, and is not reimbursable by Medicaid unless the criterion for SPMI is met. Medicare does not reimburse for Case Management services for any population.

Case management services will follow the existing State model which operates from a strengths-based perspective targeting treatment towards the unique needs of each individual. These services include but are not limited to individual support, socialization activities, linkage with the community, and finding resources needed for transportation, medication management, and medical needs. The services also promote linkage with natural resources including church, family, and local groups to address specific emotional, social, physical, and spiritual needs.

Education is needed for not only the general public but also for other service providers and agencies working with the elderly. Education about mental health and substance abuse is essential to identifying older adults in need of treatment and to combat stigma. The Senior Outreach Services Consortium will arrange public and agency educational programs focusing on addressing myths and misconceptions regarding mental and substance abuse problems.

Presentations regarding mental health, normal aging, and substance abuse issues will be provided in the community at Senior Centers, senior meal sites, residential retirement complexes, assisted living facilities and any other congregational areas for older adults. In a similar fashion, presentations and trainings for service providers will increase their ability to recognize and identify signs and symptoms of mental health and substance abuse problems facilitating identification and referral of older adults in need of services.

Feedback from clients who have participated in the pilot Senior Outreach Services project at First County has emphasized the benefit of community involvement and of connecting with others who share similar challenges. Community support groups provide hope by increasing the realization that others have been there, survived, and moved forward with their lives. The establishment of natural and community supports for clients after discharge is important to help maintain treatment gains. The Senior Outreach Services Consortium members will work together to identify what support groups are needed and lacking in First and Second County. The goal is for the Consortium to develop and maintain a minimum of two new support groups in these communities over the three year grant period that will provide seniors with community resources for support.

*Healthy People 2010 Initiative:*

In the Healthy People 2010 Initiative, there are ten leading health indicators identified that will be used to measure the health of the United States by the year 2010. Three of the ten leading health indicators are addressed in this project. These include mental health, substance abuse, and access to health care. The Healthy People 2010 Initiative focuses on increased quality and years of a healthy life and elimination of health disparities. Both are key areas addressed in this proposal.

Addressing mental health issues is noted in the Healthy People 2010 Initiative as being central to improved functioning that allows the person to have a higher quality of life. Good mental health allows the individual to participate in productive activities, have fulfilling relationships, and to be able to adapt to change and cope with adversity. Mental health is necessary to personal well-being, positive family and interpersonal relationships, and ability to contribute to society. The Healthy People 2010 Initiative points out that older adults are particular vulnerable in terms of having higher rates of depression. One of the goals outlined in the Healthy People 2010 Initiative is that services will be provided to 50% of adults with depression by the target date of 2010.

The Healthy People 2010 Initiative identifies a number of barriers that limit access to health care. These include financial, structural, and personal barriers. All three of these barriers exist for older adults in need of mental health or substance abuse treatment and are addressed in this project.

In this proposal, financial barriers are addressed through sliding scale fees for services, a zero fee option for hardship cases, and assistance of a Case Manager to facilitate accessing resources including assistance in finding financial resources for health care. Structural barriers involving a lack of knowledgeable health care professionals to meet geriatric mental health and substance

abuse treatment needs are addressed through the addition of specialized service providers and education of existing providers. Personal barriers for the target population include the stigma older people associate with seeking or receiving mental health or alcohol/drug treatment services. Lack of realization of the availability or benefit of mental health and substance abuse treatment services is another personal barrier. The Senior Outreach Services Consortium will focus heavily on addressing these personal barriers through outreach, community education, and delivery of community based services.

*Goals Strategies, Activities, Responsible Agents, and Completion Dates:*

Proposed goals and objectives in response to the identified needs of the rural communities of First County and Second County, State, for the Senior Outreach Services Consortium are as follows:

Goal I: Develop and maintain a consortium of agencies involved in elder care to address mental health and substance abuse treatment needs and related issues for older adults.

*Objectives/Strategies:*

- The lead agency in this project, First County Mental Health Center, will organize key providers and develop a Senior Outreach Services Consortium that will include aging services, public health, area hospitals, and assisted living facilities that will expand and sustain itself. Over time it is hoped that this Consortium can continue to grow with primary care physicians and service recipients also becoming involved.

*Activities:*

- The SOS Consortium will identify needs and formulates steps for service improvement and resource expansion.
- The SOS Consortium will provide input, feedback, and modifications to project goals as needed.

*Responsible Agents:*

First County Mental Health Center, the applicant agency, will be responsible for the initial development of the Consortium and ensuring that the Consortium continues as a viable functioning entity. The members of the Consortium will be responsible for fulfilling their commitments as stated in the individual Memorandums of Agreements and for providing feedback and recommendations to the applicant agency regarding achieving the overall goals of the project.

*Outcomes and/or Process Measures:*

- Increased collaboration between providers will be demonstrated by regular monthly contact between Consortium members.
- Quarterly meetings with be held with a minimum of 2/3 of the membership in attendance at each meeting.
- Satisfaction surveys will be distributed to members on a six month basis that will ask for ratings on the perceived benefit of the project to the target population. The surveys will request feedback on strengths and areas for improvement. Results of these surveys will

be totaled with feedback provided to the Consortium membership to provide ongoing evaluation of the project.

*Completion Dates:*

Memorandums of agreement have already been obtained between the nine SOS Consortium members. Upon notification of funding, this group will have an initial meeting within 30 days, and will meet on a quarterly (every 3 month) basis beginning May 1, 2007, and continuing through out the project. Phone contacts with each member of the Consortium will occur monthly. Satisfaction surveys will be distributed every six months to provide feedback regarding progress and suggestions for improvements and modifications to the project.

Goal II: Improve elder care by providing increased access to mental health and substance abuse treatment services.

Access to health care is identified in the Healthy People 2010 Initiative as one of ten focus areas that needs to be addressed to promote a healthier society. It is estimated that there are potentially 2,137 persons age 60 or older in need of mental health services and between 1,079 to 1,618 persons age 60 and above in need of substance abuse treatment services in Second and First County. Records at First County Mental Health Center reflect only 280 persons age 60 or over being treated for mental health and 25 older adults treated specifically for substance abuse from July 1, 2005, to June 30, 2006.

*Objectives/Strategies:*

- The Senior Outreach Services Consortium will expand mental health and substance abuse service delivery for adults age 60 or older in First County and initiate community based services in Second County. The objective will be to address access barriers noted in the Healthy People 2010 Initiative. These access barriers include financial, structural, and personal obstacles that prevent seniors from seeking services.

*Activities*

- Financial access barriers will be addressed through a sliding scale fee with zero fee availability for hardship cases.
- To address structural access barriers associated with a deficit of service providers one full time equivalent (FTE) clinician and one full time equivalent (FTE) case manager will be recruited to join efforts with the existing First County Mental Health Center Senior Outreach Services Coordinator/Clinician and Senior Outreach Services Case Manager to expand outreach and community based services in First County and initiate these services for seniors in Second County.
- Activities to address personal barriers will include outreach and service delivery to clients in their homes and communities and education of older adults and care providers regarding misconception and myths related to mental illness and addiction to reduce stigma.

*Responsible Agents:*

First County Mental Health Center Senior Outreach Clinicians and Case Manager; Senior Outreach Services Consortium will facilitate referrals and assist with community and target population education.

*Completion Dates:*
The sliding scale fee system will be in place at the beginning of the project, May 1, 2007. Recruitment of two addition staff will begin immediately upon notification of funding with a completion date of May 1, 2007, to join efforts with existing staff. The project coordinator is already employed at First County Mental Health Center and has had significant input into development of this proposal. Activities to address personal barriers have already begun and will be expanded by this project.

*Outcomes and/or Process Measures:*

- Increased numbers of older adults (60 and above) will access services resulting in increased mental health and substance abuse services for this population.

  *a)* During fiscal year 2006 (July 1, 2005 to June 30, 2006), 280 seniors with mental health issues and 25 with alcohol and drug treatment needs were served at First County Mental Health Center. With the addition of two additional staff, it is projected that a total of 450 adults age 60 and over will be served through programs at First County Mental Health Center the first year of grant funding (an increase of 145) with 3500 projected encounters.

  b) For Year II, the total of older adults served by the agency is projected at 465. SOS will have 3700 SOS encounters and 160 direct recipient of the program.

  c) In grant Year III, a projected total of 480 older adults or more will receive services through First County Mental Health Center (175 program recipients for Senior Outreach Services with 3,950 encounters).

  Assessment of these outcomes will be completed at the end of each grant year (i.e. April 30, 2008; April 30, 2009; and April 30, 2010.)

<u>Goal III:</u>
Improved mental health status for program recipients in Second and First County as evidenced by decreased symptoms of mental illness and substance abuse resulting in improved quality of life and functioning.

The Healthy People 2010 Initiative identifies mental health and substance abuse treatment services as two of the ten leading areas that need to be addressed for a healthier society. Addressing mental health and substance abuse needs for older adults enhances quality of life, improves overall functioning, reduces risk of psychiatric hospitalizations, reduces suicide risk, increases the ability of the older adult to live independently, and decreases potential related physical health problems.

*Objectives/Strategies:*

Through community based services, mental health and substance abuse treatment will be provided according to an individualized treatment plan developed in collaboration with the client and other relevant community service providers including the primary care physician when possible. The objectives are to reduce and/or eliminate symptoms, improve functioning, and enhance quality of life.

A*ctivities:*

- Outreach to each referral from the Consortium will be made by a qualified clinician for assessment of service needs
- Mental health and substance abuse treatment services will be provided by a qualified clinician based on identified need
- Case Management services will be provided based on individualized treatment plans developed with the program recipient and clinician

*Responsible Agents:*
Senior Outreach Services Clinicians and Case Managers will provide direct services. The Senior Outreach Services Consortium will review outcome results and provide suggestions for outcome improvement as needed. Pittsburg State University located approximately 60 miles from First County Mental Health Center in Brownsville, State, has agreed to provide technical assistance with analysis of outcomes.

*Completion Date:*
Mental health and substance abuse treatment services will be in place at the initiation of the project as will Case Management services and will continue through out the duration of the funding period, May 1, 2007 to April 30, 2010.

*Outcomes and/or Process Measures:*
Improve mental health status and substance abuse issues for Senior Outreach Service recipients as indicated by the following:

- Symptom reduction as indicated by score reduction on the Clinical Assessment Scale for Elderly (CASE). At admission program recipients will be given the Clinical Assessment Scale for Elderly (CASE) to establish treatment needs and develop a symptom profile. Upon treatment completion, the CASE will be re-administered for comparison of symptoms at discharge versus admission. The CASE contains validity scales and provides an assessment of ten symptom areas as follows: Anxiety, cognitive competence, depression, fear of aging, mania, obsessive-compulsive, paranoia, psychoticism, somatization, and substance abuse. Ratings can be provided by the individual, a caregiver, or a significant other.

- Improved quality of life reported by program participants. Sixty percent of clients will report improved quality of life as evidenced by scores on the Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q). This instrument will be administered at admission, 90 day intervals, and at the completion of treatment. The Q-LES-Q is a sixteen item questionnaire developed by the Positive Aging Resource Center that requires the individual to relate their overall level of satisfaction with various areas

of their life ranging from physical health and mood to satisfaction and general contentment during the past week. In addition, program participants will be asked to rate their level of satisfaction with life on a one to ten scale with one being very dissatisfied and 10 being extremely satisfied.

- Increased involvement with family members and friends based on self-report. A client status report will be completed every 90 days that will ask the client to report on the amount of contact with family and/or friends and indicate whether they have interacted with family and/or friends 3 to 7 days per week on average, 1-2 days per week on average, or less than once a week. They will also be asked to rate their level of satisfaction with relationships on a one to ten scale with one being poor and 10 being excellent.

- Increased community participation based on self-report. A client status report will be completed every 90 days that will ask the client to report on their level of community participation and indicate whether they have engaged in a social or civic community activity less than once a week on average; 1-2 days per week on average; or 3-7 days per week on average. They will also be asked to rate their level of satisfaction with social and community participation on a one to ten scale with one being poor and 10 being excellent.

- Prevention of the need for a more restrictive residential setting. Seventy-five percent (75%) of program recipients will remain in the community during delivery of outpatient treatment services and for a minimum of six months after discharge from the program.

- Program recipients will remain in the community and not require inpatient treatment for mental illness or substance abuse. Ninety percent (90%) of program recipients will not be psychiatrically hospitalized nor need residential alcohol drug treatment during outpatient treatment services and for a minimum of six months after discharge from the program.

Goal IV: Reduce stigma and increase community awareness of mental health and substance abuse issues for older adults in the First and Second County communities through the Senior Outreach Services Consortium. Stigma is considered the major barrier, especially in rural communities, to older adults seeking mental health and substance abuse services. In addition, older adults may not be aware of service availability or realize the benefit of mental health and substance abuse treatment.

- *Objectives/Strategies:* Provide information and education to the community, target population, and other service providers to increase knowledge of mental health and substance abuse problems.

  The SOS Consortium will provide informational programs and screenings targeting seniors through presentations at sites where seniors congregate and health fairs. Educational programs will be provided by the SOS Consortium to other community agencies and health care providers focusing on identification and recognition of

symptoms of mental illness and substance abuse in seniors to facilitate identification of problems and early referral

*Activities:*

- The Senior Outreach Service Consortium will provide a minimum of eight community education programs per year targeting senior sites.
- A minimum of six in-service training programs will be provided through the Consortium each year of the project.
- A community presentation evaluation form will be utilized to assess benefits of the trainings and public education programs. Specific questions on the form will focus on the extent to which the presentation increased understanding of mental health and substance abuse treatment needs for seniors and whether the information was helpful in overcoming misconceptions contributing to the stigma associated with mental health and substance abuse services.

*Responsible Agents:* Senior Outreach Service Consortium (all members).

*Completion Date:* Eight community education and six agency in-service trainings will be provided during each funded year for a total of 42 presentations over the 3 year funding period, May 1, 2007 to April 30, 2010. Results for each individual presentation plus annual results will be calculated and reported to the Consortium for feedback and suggestions regarding any needed improvements in the presentations.

*Outcomes and/or Process Measures:*
A one page presentation evaluation form will be given to program attendees where they will be asked to complete the typical presentation ratings in terms of the instructor's knowledge, ability to communicate ideas, and ability to keep presentation interesting. Program attendees will also be asked to report on whether the presentation increased their knowledge of mental health and substance abuse issues for senior and if the presentation had a positive impact on their attitude toward seeking mental health and substance abuse treatment. Attendees will be asked to provide a rating on a 1 to 5 scale with 1 being "not helpful" and 5 being "very helpful". The targeted outcome will be an average of a 3.5 rating or higher on these two questions.

**WORK PLAN**

YEAR I

| Goals | Strategies | Activities | Responsible Agency/Person | Outcomes and/or Process Measures | Completion Date |
|---|---|---|---|---|---|
| **Goal I:** Develop & maintain a consortium to address elder care needs | A. Organize key providers | 1) Consortium identifies needs<br><br>2) Consortium formulates steps for improvement<br><br>3) Consortium provides input & feedback for project improvement | a) First County Mental Health<br><br>b)Consortium members | Monthly communication<br><br>Attendance at meetings<br><br>Satisfaction surveys to provide feedback | Monthly<br><br>Quarterly<br><br>Every six months |
| **Goal II**: Improve elder care by providing increased access to mental health/substance services | A. Expand mental health/substance abuse services for seniors in First County.<br><br>B. Initiate community based services in Second County. | 1) Address barriers as follows:<br><br>a. *Financia*l – Provide sliding scale fee<br><br>b. *Structural* – Add 1 FTE clinician & 1 FTE case manager to existing staff of 2 FTE service providers<br><br>c. *Personal* – Outreach and in-home service delivery<br><br>2) Education of target population, community, and providers | a) First County Mental Health<br><br>b) First County Mental Health & SOS project director<br><br>c) First County Clinicians and Case Managers<br><br>First County Clinicians, Case Managers, and Consortium | More seniors access services as evidenced by increased service recipients (450 total agency participants with 145 recipients of SOS project) | Annual review<br><br>At beginning of the program<br><br>At beginning of the program<br><br>Ongoing through out year<br><br>Ongoing through out the year |

| | | | | | |
|---|---|---|---|---|---|
| **Goal III :**<br>Improve mental health status for program recipients | A. Reduce and/or eliminate symptoms<br><br>B. Enhance quality of life<br><br>C. Improve functioning | 1) Outreach to referrals<br><br>2) Provide community based mental health and substance abuse treatment<br><br>3) Provide community based Case Management | a) First County Clinicians & Case Managers | Symptom improvement as indicated by scores on the CASE<br><br>Increased quality of life as indicated by scores on the Q-Les-Q and self-rating<br><br>Client Status Reports will reflect increased involvement with family members/ friends and satisfaction with relationships; increased community involvement and satisfaction<br><br>Prevent placement in long-term care<br><br>Reduce inpatient treatment for psychiatric and substance abuse | Individual admission & discharge<br><br>Quarterly<br><br>Quarterly<br><br>Quarterly & six months after program completion<br><br>Quarterly & 6 months after program completion discharge |
| **Goal IV:**<br>Reduce stigma and increase community awareness of mental health and substance abuse issues for seniors | A. Educate older adults , the general public, other service providers | 1) Provide a minimum of eight community education programs<br><br>2) Provide a minimum of six in-service trainings to organizations serving older adults | a) Consortium and First County | Community members and service providers will report increased understanding of mental health and modified attitudes (average rating 3.5 or above on surveys) | Through out Year I funding |

YEAR II

| Goals | Strategies | Activities | Responsible Agency/Person | Outcomes and/or Process Measures | Completion Date |
|---|---|---|---|---|---|
| **Goal I:** Maintain and enhance consortium to address elder care needs | A. Encourage members participation and attendance<br>B. Recruit new members | 1) Consortium identifies ongoing needs<br><br>2) Consortium formulates steps for improvement<br><br>3) Consortium provides input & feedback for project improvement | a) First County Mental Health<br><br>b) Consortium members | Monthly communication<br><br>Attendance at meetings<br><br>Satisfaction surveys to provide feedback | Monthly<br><br>Quarterly<br><br>Every six months |
| **Goal II**: Improve elder care by providing increased access to mental health/substance services | A. Expand mental health/substance abuse services for seniors in First and Second County. | 1) Address barriers as follows:<br><br>*a. Financia*l – Provide sliding scale fee & look for additional funding sources to subsidize fees<br><br>*b. Structural* – Maintain staff to provide services<br><br>*c. Personal* – Outreach and in-home service delivery<br><br>2) Education of target population, community, and providers | a) First County Mental Health<br><br>b) First County Mental Health<br><br>c) First County Clinicians and Case Managers<br><br>d) First County Clinicians, Case Managers, and Consortium | More seniors access services as evidenced by increased service recipients (465 total agency service recipients 60 or older with 160 SOS participants) | Annual review<br><br>Ongoing through out the year<br><br>Ongoing through the year<br><br>Ongoing through out year<br><br>Ongoing through out the year |

| | | | | | |
|---|---|---|---|---|---|
| **Goal III :**<br>Improve mental health status for program recipients | A. Reduce and/or eliminate symptoms<br><br>B. Enhance quality of life<br><br>C. Improve functioning | 1) Outreach to referrals<br><br>2) Provide community based mental health and substance abuse treatment<br><br>3) Provide community based Case Management | a) First County Clinicians & Case Managers | Symptom improvement as indicated by scores on the CASE<br><br>Increased quality of life as indicated by scores on the Q-Les-Q and self-rating<br><br>Client Status Reports will reflect increased involvement with family members/ friends and satisfaction with relationships; increased community involvement and satisfaction<br><br>Prevent placement in long-term care<br><br>Reduce inpatient treatment for psychiatric and substance abuse | Individual admission & discharge<br><br>Quarterly<br><br>Quarterly<br><br>Quarterly & six months following treatment completion<br><br>Quarterly & six months following treatment completion |
| **Goal IV:**<br>Reduce stigma and increase community awareness of mental health and substance abuse issues for seniors | A. Educate older adults , the general public, other service providers | 1) Provide a minimum of eight community education programs<br><br>2) Provide a minimum of six in-service trainings to organizations serving older adults | a) Consortium and First County | Community members and service providers will report increased understanding of mental health and modified attitudes (average rating 3.5 or above on surveys) | Through out Year II funding |

## YEAR III

| Goals | Strategies | Activities | Responsible Agency/Person | Outcomes and/or Process Measures | Completion Date |
|---|---|---|---|---|---|
| **Goal I:** Maintain and enhance consortium to address elder care needs | A. Encourage members participation and attendance<br><br>B. Continue to recruit new members | 1) Consortium identifies ongoing needs<br><br>2) Consortium formulates steps for improvement<br><br>3) Consortium provides input & feedback for project improvement | a) First County Mental Health<br><br>b) Consortium members | Monthly communication<br><br>Attendance at meetings<br><br>Satisfaction surveys to provide feedback | Monthly<br><br>Quarterly<br><br>Every six months |
| **Goal II**: Improve elder care by providing increased access to mental health/substance services | A. Expand mental health/substance abuse services for seniors in First County and Second County | 1) Address barriers as follows:<br><br>*a. Financia*l – Provide sliding scale fee & look for additional funding sources to subsidize fees<br><br>*b. Structural* – Maintain staff to provide services<br><br>*c. Personal* – Outreach and in-home service delivery<br><br>2) Education of target population, community, and providers | a) First County Mental Health<br><br>b) First County Mental Health<br><br>c) First County Clinicians and Case Managers<br><br>d) First County Clinicians, Case Managers, and Consortium | More seniors access services as evidenced by increased service recipients (480 total agency service recipients with 175 SOS client) | Annual review<br><br>Ongoing through out the year<br><br>Ongoing through the year<br><br>Ongoing through out year<br><br>Ongoing through out the year |

| | | | | | |
|---|---|---|---|---|---|
| **Goal III :**<br>Improve mental health status for program recipients | A. Reduce and/or eliminate symptoms<br><br>B. Enhance quality of life<br><br>C. Improve functioning | a) Outreach to referrals<br><br>b) Provide community based mental health and substance abuse treatment<br><br>c) Provide community based Case Management | a) First County Clinicians & Case Managers | Symptom improvement as indicated by scores on the CASE<br><br>Increased quality of life as indicated by scores on the Q-Les-Q and self-rating<br><br>Client Status Reports will reflect increased involvement with family members/ friends and satisfaction with relationships; increased community involvement and satisfaction<br><br>Prevent placement in long-term care<br><br>Reduce inpatient treatment for psychiatric and substance abuse | Individual admission & discharge<br><br>Quarterly<br><br>Quarterly<br><br>Quarterly & six months following program completion<br><br>Quarterly & 6 months following program completion |
| **Goal IV:**<br>Reduce stigma and increase community awareness of mental health and substance abuse issues for seniors | A. Educate older adults , the general public, other service providers | 1) Provide a minimum of eight community education programs<br><br>2) Provide a minimum of six in-service trainings to organizations serving older adults | a) Consortium and First County | Community members and service providers will report increased understanding of mental health and modified attitudes (average rating 3.5 or above on surveys) | Through out Year III funding |

## RESOLUTION OF CHALLENGES

Dealing with the stigma older adults in a rural community associate with mental health and substance abuse treatment is the biggest challenge for this project. Education is essential to help older adults realize it is not shameful to need or seek mental health or substance abuse treatment. Providing educational presentations to the target population and service providers, including primary care physicians, will be very important. Knowledge and understanding can and does change attitudes. Reduction of stigma will also come as seniors utilize services and share positive accounts about their experiences with the program.

The second major challenge will be "selling" this project to primary care providers, seniors, family members, and others who come into contact with the target population. If primary care providers and agencies who work with older adults are not aware of the project or not informed about the potential benefit, older adults and their families are not going to be directed to these services.

The Senior Outreach Services Consortium will need to be diligent in their efforts to make primary care physicians, service providers, seniors, family members, and the community at large aware of the program. This challenge will be addressed through personal contacts, community presentations, and providing informational brochures at physician's offices, public health departments, senior centers, health fairs, and other community agencies that serve seniors. In addition, newspaper articles about the project and public service radio spots will be another method of informing the community. As the project expands, "word of mouth" will further facilitate awareness.

Education about the existence of the program must be ongoing for this project to be successful. Typically people tend to not "tune in" to advertisements or public service announcements until it becomes something that is personally relevant to them.

Another challenge is keeping a dedicated focused Consortium and expanding the Consortium. The applicant organization, First County Mental Health Center, will be responsible for ensuring that Consortium members are actively involved. In order for this project to survive and grow beyond the grant funding years, the Consortium membership will need to expand with inclusion of a wider representation of the community. For example, service recipients or family members of service recipients and primary care physicians would have a great deal to offer to this group.

## EVALUATION

Dr. Jones with the Department of Psychology and Counseling at Brownsville State University has verbally agreed to serve as an external evaluator for this project. Brownsville State University is located in Brownsville, State, approximately 60 miles east of First County Mental Health Center's main office site in Independence. First County Mental Health Center has a positive history of working collaboratively with Brownsville State University through providing training placements for psychology students.

*Process Measures and/or Outcome Measures*

In this project, there are four primary goals that will be addressed:

1) Establish a Consortium to focus on mental health and substance abuse treatment needs for older adults in First and Second County, State.
2) Improve elder care by providing increased access to mental health and substance abuse treatment services.
3) Improve mental health status for program recipients in Second and First County.
4) Reduce stigma and increase community awareness of mental health and substance abuse issues for older adults.

Methods to assess progress and measure outcomes have been developed for each of these primary goal areas. A variety of data collection methods will be employed, including but not limited to, completion of Client Status Reports (refer to Attachment #11 for forms); use of pre and post measures administered at admission and program completion; six month follow-up assessments; and use of client satisfaction surveys (included in Attachment #11). The following provides an overview of the process and outcome measures for each of the four primary goals.

Goal I: Develop and maintain a consortium of agencies involved in elder care to address mental health and substance abuse treatment needs and related issues for older adults.

*Outcomes and/or Process Measures:*

- Regular monthly contacts will occur between Consortium members.
- Quarterly meetings with be held with a minimum of 2/3 of the membership in attendance at each meeting.
- Satisfaction surveys will be distributed to members on a six month basis that will ask for ratings on the perceived benefit of the project to the target population. The surveys will request feedback on strengths and areas for improvement.

*Data Collection Process, Analysis, and Review:*

- The Applicant Agency, First County Mental Health Center, will track and document monthly contacts with the Consortium and maintain minutes of each quarterly meeting that include dates of the meeting and a list of attendees. First County Mental Health Center will also be responsible for distribution of six month surveys to the consortium members, and proving a summary of those surveys for feedback and recommendations.

Goal II: Improve elder care by providing increased access to mental health and substance abuse treatment services.

*Outcomes and/or Process Measures:*

- Increased numbers of older adults (60 and above) will access services
  d) A total of 450 adults age 60 and over will be served through programs at First County Mental Health Center the first year of grant funding (an increase of 145) with 3500 projected encounters.

e) For Year II, the total of older adults served by the agency is targeted at 465 (an increase of 160) with 3700 encounters
f) In grant Year III, a projected total of 480 older adults or more will receive services through First County Mental Health Center (an increase of 175) with 3,950 encounters.

*Data Collection Process, Analysis, and Review:*
Records will be maintained by First County Mental Health of the number of clients served and each client encounter including outreach contacts. The information technology system at First County Mental Health Center allows reports to be generated that provide data about the age of service recipients, type of services delivered, and program or department providing the services. This information can be accessed for any specified time period. This will make it easy to track and report on the above goals.

Goal III: Improved mental health status for program recipients in Second and First County as evidenced by decreased symptoms of mental illness and substance abuse resulting in improved quality of life and functioning.

*Outcomes and/or Process Measures:*

- Symptom reduction as indicated by score reduction on the Clinical Assessment Scale for Elderly (CASE).
- Improved quality of life reported by program participants as evidenced by scores on the Qualify of Life Enjoyment and Satisfaction Questionnaire – Short Form and by self-ratings.
- Increased involvement with family members and friends based on self-report as an indicator of improved functioning.
- Increased community participation based on self-report as an indicator of improved functioning.
- Prevention of the need for a more restrictive residential setting. Seventy-five percent (75%) of program recipients will remain in the community during delivery of outpatient treatment services and for a minimum of six months after discharge from the program.
- Program recipients will remain in the community and not require inpatient treatment for mental illness or substance abuse. Ninety percent (90%) of program recipients will not be psychiatrically hospitalized nor need residential alcohol drug treatment during outpatient treatment services and for a minimum of six months after discharge from the program.

*Data Collection Process, Analysis, and Review:*
Instruments to be used for outcome and process measures are the Clinical Assessment Scale for Elderly (CASE), the Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form, Admission Client Status Report, Quarterly Client Status Report, and Discharge Client Status Report. The plan is for data to be submitted to Brownsville State University for outcome analysis with feedback provided to the Senior Outreach Services Consortium for use in quality improvement efforts.

The Clinical Assessment Scale for Elderly (CASE) will be administered at program admission and re-administered at program completion to assess the effectiveness of treatment in alleviating or reducing symptoms. First County Mental Health Center, as the direct service provider in this project, will provide oversight of the administration of this instrument.

The Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q) will be used to assess whether or not participants perceive their quality of life and satisfaction with life as improving. First County Mental Health Center will be responsible for data collection. This instrument will be administered at admission, 90 day intervals, and at the completion of treatment. Program participants will be asked to rate their level of satisfaction with life on a one to ten scale with one being very dissatisfied and 10 being extremely satisfied. Ratings will be reported on the quarterly Client Status Report.

On the quarterly Client Status Report, clients will be asked to report on the amount of contact with family and/or friends over the past quarter and to indicate whether they have interacted with family and/or friends 3 to 7 days per week on average; 1-2 days per week on average; or less than once a week. They will also be asked to rate their level of satisfaction with relationships on a one to ten scale with one being poor and 10 being excellent. Rating will be recorded on the quarterly Client Status Report.

The target is seventy-five percent (75%) or more of program recipients will remain in the community during delivery of outpatient treatment services and for a minimum of six months after discharge. Ninety percent (90%) will not require psychiatric inpatient or residential alcohol drug treatment during the program and for a minimum of six months after discharge. These two indicators will be included on the Client Status Report and will be tracked by First County Mental Health Center at admission, 90 day intervals, at discharge, and six months after discharge.

Goal IV: Reduce stigma and increase community awareness of mental health and substance abuse issues for older adults

*Outcomes and/or Process Measures:*
Attendees at community education programs will report that the presentation increased their understanding of mental health and substance abuse issues and had a positive impact on their attitude toward seeking mental health and substance abuse treatment. Attendees at in-service training programs for staff of agencies providing services to older adults will report that the presentation increased their understanding of mental health and substance abuse issues and had a positive impact on their attitude toward individuals who seek mental health and substance abuse services.

*Data Collection Process, Analysis, and Review:*
A presentation evaluation form will be provided to attendees at community education and in-service training programs. Program attendees will be asked to report on whether the presentation increased their knowledge of mental health and substance abuse issues for seniors and had a positive impact on their attitude toward seeking services. A one (1) to five (5) rating scale with be used with 1 being “not helpful” and 5 being “very helpful”. The targeted outcome will be an

average of a 3.5 rating or higher on these two questions. Senior Outreach Services Consortium members involved in providing the presentation will be responsible for raw data collection. First County Mental Health Center staff will calculate results and provide written feedback regarding presentations at each quarterly meeting.

*Other Data Collection Process, Analysis, and Review:*
In addition to the process and outcome measures provided in the above section, a client satisfaction survey will be administered to program participants on a quarterly basis that will ask not only about the level of satisfaction with available services, but will also ask clients to rate how helpful each service was, and how the project could be improved. Results of these surveys will be tabulated and reviewed as a part of an on going quality improvement process.

**IMPACT**

The Mental Health American Geriatrics Society (AGS) noted in their report on Mental Health and the Elderly Position Statement (January 1, 1993) that mental illness is an important contributing factor to the disease burdens on the elderly, and that treatment for this population has been ignored and neglected with only 4% of community mental health center patients being over age 65. Chapter 5 of the Surgeon General's report on mental health and older adults emphasizes that mental disorders are leading risks factors for institutionalization (Katz & Parmelee, 1997), and that more focus needs to be directed to addressing mental disorders for this population in order to avoid costly institutionalization. It is also noted in the report that the focus is shifting more and more toward community based treatment.

Treating mental disorders at the community level before they progress or result in serious co-morbid medical problems can prevent costly out of home placements and reduced quality of life for older adults. Out of home placements in either a psychiatric treatment facility or long-term care facility, such as a nursing home, can add up to thousands of dollars in a very short time.

Older adults who abuse alcohol and prescription drugs are at increased risk for falls, injuries, accidental overdose, dependency, and impaired ability to function independently. Obviously all of these can lead to increased cost to the health care system plus produce the added result of degraded quality of life for the individual and his or her family.

Untreated depression can result in serious consequences, especially for older individuals. Major depression in the elderly can produce symptoms that may be misdiagnosed as dementia or Alzheimer's and result in unnecessary institutional placement robbing the individual of years of a better quality of life and costing the system thousands of dollars. Likewise untreated mental health and substance abuse can increase health care utilization. Research has demonstrated that individuals suffering from untreated depression are at much greater risk for development of health problems. In fact, insurance companies tend to be reluctant to write health insurance for even younger persons who have had experienced mental health problems, particularly depression. The insurance actuary tables reveal that mental health issues and physical health issues are highly correlated. The cost of long-term residential health in this area is approximately $3,500 to $4,000 per month. If this project allows only four individuals to remain in their own homes for an additional twelve month time period, this represents a potential

savings of $168,000 to $192,000 per year to the system. Quality of life benefits for these individuals and the positive impact for families of a loved one remaining independent for additional days or months is something that a dollar and cent value can not be placed upon.

The impact of treating mental health and substance abuse issues for older adults is significant in terms of reduced suicide risk, reduced hospitalizations for psychiatric and substance abuse treatment, avoiding of costly premature placement in nursing homes, and reduction of general medical health care costs.

In an article on defining best practices for geriatric mental health published in the Canadian Journal of Psychiatry (July, 2004), the importance of community-based service delivery through specialized geriatric mental health outreach services involving shared care across systems or agencies is noted as an effective approach to treatment of older adults. Research by Citters and Bartel (2004) have found home based services to be effective in identifying older adults with mental illness and improving psychiatric symptoms.

In State, the community based service initiative associated with mental health reform has made a positive impact on reducing psychiatric bed days. This initiative has targeted adults identified as severely and persistently mentally ill (SPMI) and children identified as severely emotionally disturbed (SED). The case management component has proven very effective in facilitating connection with community resources that have resulted in reduced hospitalizations for these adults and children, symptom reduction, and improved quality of life. Community based case management services have proven to be an effective model for other populations and has significant merit as a treatment model for older adults.

The target population in local communities will experience benefits of increased quality of life, reduction of symptoms, and reduced fear of seeking help for mental health and substance abuse needs. In short, the people who are served will have more meaningful lives in the community not a nursing facility. For example, staff of the pilot project provided services to a 92 year old client, who considered herself worthless and was contemplating suicide when services began. When services were complete, she had found a way to establish meaning in her life. In fact, she won grand champion at the local fair with her needlework. This was an amazing turnaround for this individual, which will be replicated with the expanded services provided by this project.

The local community as a whole will benefit by having increased knowledge and reduced stigma towards mental health services. Presentations, surveys, and individual interviews have shown a sense of relief that help is available for seniors. Family members/caregivers also have provided extremely positive feedback on how the program has reduced stigma and access barriers to mental health services. The combined establishment of the program along with continued aging of the baby boomers will lead to greater acceptance at the community level of the benefit of seeking services. As the community becomes more comfortable, it is likely that increasing numbers of seniors will seek help with less outreach required.

First County Mental Health Center is a part of a network of a twenty eight community mental health centers that form the Association of Community Mental Health Centers in State. The Association of Community Mental Health Centers meets on a monthly basis to discuss State

wide issues for community mental health and to share information about programs and projects that have been successful at different centers. Association members also participate in the National Council for Community Behavioral Healthcare.

Information about this project and outcomes will be distributed at the State level to the Association of Community Mental Health Center in State, and in turn will have a mechanism to be communicated on to the National Council for Community Behavioral Healthcare for distribution at the national level. Currently, there is strong interest among the community mental health centers in State in finding avenues to better serve older adults which are becoming an ever larger population in the state. Information about the project will also be shared at the state level with the State Department of Aging. The Governor's Conference on Aging which is held annually in the capital would provide an excellent venue for sharing information and outcomes regarding the project.

At the community level information will be shared with the First and Second County Commissions, both of whom provided letters of support for the project, and with local civic groups who might have an interest in the project. Information about the project and outcomes would also be posted on First County's external website.

This project is one that could easily be replicated in other rural communities with similar needs. Rural communities have a great advantage over large metropolitan centers in forming Consortiums to address specific issue. Because the communities served and agencies within the community are much smaller, the same key individuals and resources come into play with a variety of projects and services and know each other by first name. The community based outreach approach and case management component would also be adaptable to urban settings, and could be implemented in metropolitan areas as well.

**RESOURCES AND CAPABILITIES**

The applicant organization for this project is First County Mental Health Center, a private non-profit community mental health center located in Southeast State. First County has been the primary provider of outpatient mental health and substance abuse services in First, Second, Third and Fourth Counties since 1964. A Board of Directors, comprised of citizens from a variety of backgrounds and professions along with a consumer and consumer family representative, governs the operations of the agency. The mission statement of the agency is as follows: "First County is dedicated to providing accessible, innovative mental health services in partnership with consumers, families, and communities". This mission statement embodies the focus of the Rural Health Care Services Outreach Grant Program in terms of the emphasis on access, innovation, and partnerships. A part of the vision of First County is the development of healthier communities through collaboration with community partners. Core values of the agency include commitment, leadership, partnership, equality, availability, quality, outcomes, effectiveness and efficiency, compassion, and integrity.

The capacity to implement systems and services to meet the needs of the community has been well demonstrated in past projects. For example, First County was a participant in a southeast State five year federal demonstration grant (1994-1999) for children resulting in the Family

Centered System of Care bringing over $5 million in funding to the State. This project involved forming multiple partnerships with other service providers as well as with neighboring community mental health centers.

First County staff has provided consultation and technical assistance on program development to at least 14 of the other State community mental health centers. First County was successful in obtaining State funding through a blended grant from Mental Health and Addiction & Prevention Services to develop a demonstration grant for adults with co-occurring disorders of mental illness and substance abuse who were involved with the criminal justice system or at risk of involvement. This was the only project of its kind funded by the State. This project has been sustained for over four years and is currently partially funded through a Federal Edward Byrne Memorial Justice Assistance Grant (JAG).

Specialized service programs have been developed and implemented at First County that are not available at all community mental health centers. These programs were developed to address a variety of community needs including teen pregnancy; education and employment issues for persons with mental illness; day treatment for children with severe emotional disturbance; and parent education services provided to community residents at no cost to the public. The parent education project was begun in 1988 and has now been sustained for eighteen years. This program provides free parent education services in Second, First, Third and Fourth Counties on a variety of parenting topics. First County's teen pregnancy program, Mothers on the Move or MOM's Program, works with pregnant teens to provide information and education on prenatal care, child care and parenting, and facilitates teens accessing resources including assistance with financial needs, housing, education, and employment. First County's SEK (Successful Environment for Kids) Academy provides a needed community resource for children who are unable to be successful in a regular public school environment due to mental health issues. The goal of this project is to address mental health needs so that the child is able to return to the public school environment and succeed.

An example of one specialized collaborative program involved the State Department of Social and Rehabilitation Services approaching First County Mental Health Center to pilot a project to provide mental health, substance abuse treatment, and case management services to at risk families. These families were identified as having self-sufficiency and employment issues in addition to being at high risk for child abuse and domestic violence. This project, Extra Effort, was able to make an effective difference in this population. Family stability and self-sufficiency were facilitated through the collaborative efforts of the Department of Social and Rehabilitation Services and First County Mental Health.

First County has a positive and lengthy history of forming partnerships to address community needs. The partnership established for this project, the Senior Outreach Services Consortium, will be comprised of nine members that include representatives from aging services, public health, mental health and substance abuse services, area hospitals, and assisted living facilities.

The Senior Outreach Services Consortium members will consist of the Southeast State Agency on Aging; First County Department of Public Health; Second County Department of Public Health; Gran Villas Assisted Living Facility; Sunshine Assisted Living; Gran Villas Assisted Living Facility; The Sanctuary at Regional Hospital; and Brownsville Regional Medical Center

Behavioral Health Unit with First County Mental Health Center as the applicant agency. Each of the Consortium members has signed a Memorandum of Agreement (MOA) that outlines the Consortium member roles, responsibilities and contributions as well as the roles, responsibilities and contributions expected from the applicant agency.

The strategy for development of the Consortium was based on identifying key agencies involved in service delivery to older adults. Inclusion of the Southeast State Area Agency on Aging was an obvious choice as they have significant contact with seniors and are an ideal resource to assist in identification of needs of this population plus also a valuable resource for referral of program participants. The Southeast State Area Agency on Aging (AAA) has agreed to utilize the K-6 to identify individuals in need of mental health services and to make referrals of those individuals. The Area Agency on Aging has also agreed to communicate with the applicant organization regarding program recipients to avoid overlap of service delivery so the use of resources between the two agencies is maximized. In addition, they will schedule a minimum of one in-service training per year on recognition of mental health and substance abuse issues in the senior population. In return the applicant organization will provide at least one outreach visit for each referral without cost to the recipient or AAA; provide screening and consultation for mutual clients as needed; provide therapy and case management dependent upon the client's need; and communicate with AAA regarding referral and follow-up with client consent. The applicant organization also agrees to provide at least one educational presentation to AAA staff on recognizing mental illness in older adults.

Public health departments from First and Second County were asked to have input into this project and be a part of the Consortium. They bring to the group a good awareness of community needs in terms of public health and home health issues. The Memorandum of Agreement with First and Second County Health Departments states that the health departments will provide referrals of clients in need of services and will host one educational program per year on recognizing mental health problems in older adults. In return, First County Mental Health Center agrees to provide a minimum of one outreach visit for each appropriate referral without cost to the health department or client to assess service needs. First County will notify the health department of the outcome of the contact and collaborate on any necessary follow-up providing the program recipient provides consent for exchange of information. First County will provide one educational presentation on mental health issues in seniors to each of the county health departments in the Consortium.

Assisted Living facilities in First and Second County were included because they are key agencies involved with the aging population. Through addressing untreated depression and other mental health and substance abuse problems for this population, hopefully, moving to a higher level of care can be avoided. Agreements have been developed with three assisted living facilities that are similar in terms of the defined roles and responsibilities. Agreements with Gran Villas and Sunshine Place Assisted Living state that each of these facilities will make referrals to the Senior Outreach Services at First County Mental Health Center and will host a minimum of two educational presentations per year. One presentation will be an in-service for facility staff. The other presentation will be an informational program on mental health issues for assisted living residents. First County Mental Health SOS staff will respond with at least one outreach visit for each appropriate referral and providing screening and consultation at the

facility as needed. In addition First County staff will develop presentations for staff and for residents. Presentations provided to residents will include topics such as understanding depression, maintaining mental health, coping with holidays, and normal versus abnormal mental changes associated with aging.

Early identification of mental health and substance abuse problems by other service providers in the Consortium is essential to timely intervention and treatment. With timely mental health service delivery, the risk of further deterioration in mental and physical health resulting in impaired quality of life and decreased ability to live independently or semi-independently is reduced.

The Sanctuary at County Regional Hospital and the Behavioral Health Unit at Brownsville Regional Hospital both serve older adults who experience severe psychiatric symptoms resulting in the need for hospitalization. Both of these facilities have agreed to provide referrals for patients age 60 and older who are in need of follow-up outpatient services with the applicant agency, First County Mental Health, agreeing to provide screening and consultation at the unit and at least one outreach visit to all referrals.

In order to ensure that the grant funded project addresses the mental health and substance abuse treatment needs of seniors in First and Second Counties and that the applicant organization receives regular input from other Senior Outreach Services Consortium members, regular contacts must occur. Each Consortium member has agreed to a minimum of monthly contacts by phone with a full meeting of the Consortium to be held no less than once per quarter. Grant funds will be used to reimburse mileage and per diem expense for Consortium members. Locations of the meeting will be rotated to encourage familiarization with other agencies facilities and operations.

At the quarterly meeting, minutes of the meeting will be kept and a democratic process will be followed. The Consortium members will be provided with an update on the project that will be prepared by the applicant agency who will chair the quarterly meetings. The Consortium members will be encouraged to provide feedback regarding outcomes and recommendations regarding any needed program modifications. Decisions will be made and disagreements resolved through a majority vote.

**Request for Funding Preference**

The Senior Outreach Services Consortium requests funding preference based on meeting eligibility for both Preference 1 and Preference 2. The project is located in a designated health professional shortage area (HPSA), is a medically underserved community (MUC), and proposes to serve a medically underserved population (MUP). Second County and First County State are designated as medically underserved areas. First County is designated as a Community Mental Health Center which is required to qualify for the Medically Underserved Community (MUC) status, and has met required criteria for registration with the National Health Service Corp as a site eligible for the Loan Repayment Program (LRP) and has a HPSA score of 17.

A Preference 2 criterion requires that applicants' projects focus on primary care and/or wellness and disease prevention. The Senior Outreach Services Consortium will provide outreach and primary community based mental health and substance abuse treatment services including diagnosis and treatment. In addition, this project has a community education component that focuses on prevention as well as early identification of mental health and substance abuse issues for the elderly. Therefore, this project would qualify for Preference 2 in addition to Preference 1 consideration for funding.